KEEPING TRACK OF PROFESSIONALS WITH SUBSTANCE USE DISORDERS

A DISCUSSION ABOUT REPORTING

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This is an INTERACTIVE Presentation!

The goal here is a framework for us to have a discussion about how we are going identify gaps in the current process and to make it more difficult for diverting and abusing health care workers to fall in the gap.

Diversion Isn’t Just About Stolen Pills

David Kwiatkowski

In May 2012, patients at the Cath lab where he was working were found to have contracted Hep C - which was traced back to Kwiatkowski.

He had been injecting himself with patient medications (fentanyl) which resulted in him sharing syringes with patients.

Ultimately, 12,000 patients had to be tested and at least 45 were found to be infected.

Rocky Allen

Swedish Medical Center, Denver

Syringe-swapping for fentanyl

Fired from at least 5 health care facilities in CA, AZ, & WA.

3,000 patients invited for testing for HIV and hepatitis (results are not known at this time)

Faces 11 years + $300K fines

“Our belief is that the hospitals did only a state criminal records check and **no verification of employment backgrounds**,” Avery said in an email, “which **would have revealed the false information provided by Allen** and most importantly, his court martial on similar drug theft charges in 2011.”

What Do We Need to Discuss?

Could Such an Infection Outbreak Happen in INDIANA?

Are Hoosier Patients Going Without Their Prescribed Pain Medication Due to Diversion in Healthcare Settings?

What Are the Current Reporting Requirements in INDIANA?

What Are the Problems That Allow Diverting Healthcare Workers Go Undetected From Employer to Employer or undetected while working?

Could an Infection Outbreak Happen in INDIANA?

Sure! - why not???

150,000 Nurses

15,000 Physicians

7,000 Pharmacists

XXXX Technicians (like Kwiatkowski and Allen)

XXXX Hospitals

XXXX long term care facilities etc

Are Hoosier Patients Going Without Their Meds in Healthcare Facilities?

Diversion In Indiana

150,000 nurses in Indiana

10-15% of the general population has SUD

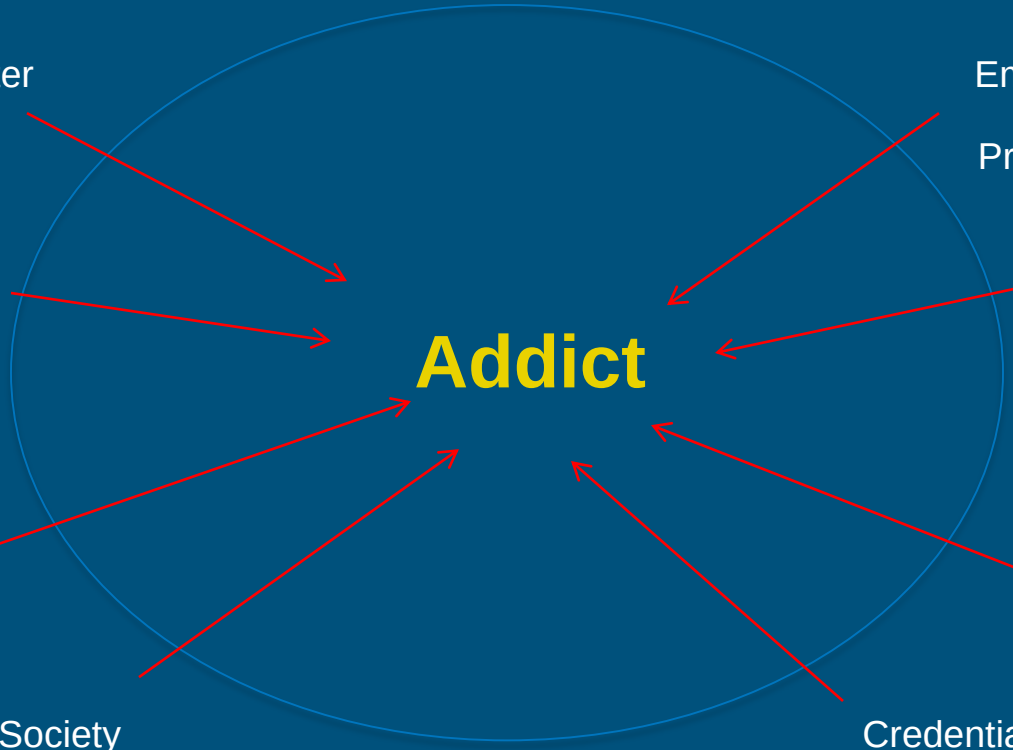
Using the low end of 10%, that means 15,000 nurses in Indiana currently have or will have a problem with SUD

ISNAP has 600 accounted for. Where are the rest?

What Are the Current Reporting Requirements in Indiana?

Seriously - Does Anyone Even Know???

Who ‘can’ the information get reported to?



Treatment Center

Employer

Professional licensing Agency

Monitoring Program

Law Enforcement
Local P.D.

DEA
OIG
OAG

Licensing Board

Society

Credentialing Committees
NPDB
CMS

Let’s Name the Scenario

Nurse A (LPN or RN) is working in a residential or long term care facility and the narcotic count is off at the end of her shift - there are three oxycodone pills missing. You suspect that Nurse A stole the pills. You also have been told that Nurse A was acting “odd” during a shift last week and that today her coworkers reported seeing her take a lot of bathroom breaks and go out to her car more than once.

What are the possible outcomes for Nurse A if she did divert? (Termination??)

Are you obligated to report any of this information, and, if so, to whom?

Do you have to tell anyone?

Law Enforcement?	
Indiana State Board of Nursing?	848 IAC 2-2-2
Drug Enforcement Administration?	21 CFR 1301.76
Indiana Board of Pharmacy	856 IAC 2-3-35(b)
Indiana State Nurses Assistance Program?	
Office of the Indiana Attorney General?	

What if the diverting employee isn’t a nurse? What if he is a CNA or Home Health Aide?

Then who do you report to?

Law Enforcement?	Sure!
Indiana State Board of Nursing?	Nope.
Drug Enforcement Administration?	Yep!
Indiana State Nurses Assistance Program?	No.
Office of the Indiana Attorney General?	No, again.

Why Can Diverting Healthcare Workers in Indiana Go from Employer to Employer?

#1 Interagency Communication

1. Interagency Communication is Sub-Par
2. Medical / Treatment History is Protected
3. The motivation is to Run vs. Ask for Help
4. Human Resources is limited on what they can ask Previous Employers
5. We live in a litigious society

What Could We Do to Close the Reporting Gap?

When a Healthcare Worker develops a SUD, what is the best approach?

Treatment + Accountability

So how do we achieve the “Accountability”?

Can Employers Tell a Potential Employer About Suspected Diversion? Colorado

8-2-111.6. Health care employers - immunity from civil liability - requirements - exception to blacklisting prohibition - legislative declaration.

(2) In response to a request by a prospective or current employer of a health care worker, it is neither unlawful nor a violation of the prohibitions against blacklisting specified in sections 8-2-110 and 8-2-111 for an employer, when acting in good faith, to disclose information known about any involvement in drug diversion, drug tampering, patient abuse, violation of drug or alcohol policies of the employer, or crimes of violence as listed in section 18-1.3-406 (2) (a), C.R.S., by the health care worker who is an employee or a former employee of the responding employer.

(3) (a) (I) An employer who provides information in accordance with subsection (2) of this section is immune from civil liability for providing the information or for any consequences that result from the disclosure of the information unless the health care worker shows by a preponderance of the evidence that the information is false and the employer providing the information knew or reasonably should have known that the information is false.

North Carolina Health Care Personnel Registry

The NC HCPR is a comprehensive listing of unlicensed health care personnel who are under investigation for an allegation (pending allegation investigation) or have a substantiated allegation finding as defined in G.S. 131E-256(a).

Information on the HCPR is available to health care employers about potential employees that have administrative actions listed including the nature of a finding or allegation and the status of an investigation.

Would a similar registry be helpful in Indiana? Why or Why Not?

What Should We Do In Indiana?